



Out-Of-Network Reimbursement Form

Submit this form along with your ****itemized receipt to:**
VSP P.O. Box 997105, Sacramento, CA 95899-7105 or
Fax to 916-851-5152

IMPORTANT NOTE:

Your itemized receipt must include the information shown below with an ******. If your receipt does not contain this information your claim cannot be processed and you will need to contact your non-VSP provider for a new receipt which includes the required information.

Member Information:

Member's ID or last four digits of Social Security Number:

Member's Name:

Date of Birth:

Address:

City:

State:

ZIP Code:

Phone Number:

Patient Information:

****Patient's Name:**

Date of Birth:

Relationship to Member:

If the patient is a child (and over the age of 18):

Is the child a full time student?

Name of School:

Is the child physically impaired?

Reimbursement Request Information:

****Date Services were received:**

****Services received (please circle any that apply and provide the amount paid for each)**

Exam \$

Lenses: Single Vision \$

Bifocal

Trifocal

Progressive

Lenticular

Lens Options:

Tint \$

Other \$

(Includes Scratch Coatings, Anti-Reflective Coatings, etc.)

Frame \$

Contact Lenses \$

Contact fittings &/or Evaluation \$

****Provider/Optical Shop Name:**

Phone Number:

Address:

City:

State:

ZIP Code:

For additional information on your eyecare benefits, please contact Customer Service at (800) 877-7195.